



## IHA Response to CMS Hospital Price Transparency Accuracy and Completeness Request for Information

### 1. Should CMS specifically define the terms “accuracy of data” and “completeness of data” in the context of these requirements, and if yes, then how?

Yes, CMS should clearly define “accuracy” and “completeness” to reduce subjective interpretation and promote consistent compliance across hospitals and payers. Perceived inaccuracies often stem not from provider noncompliance, but from payer variability and complex contractual arrangements.

Accuracy should reflect a hospital’s ability to report payer-negotiated rates as contractually agreed—not as they appear on paid claims, which may be altered by adjudication logic, bundling, or medical necessity edits beyond the hospital’s control.

Completeness should mean inclusion of all required data elements per CMS regulations, as available and applicable. Reasonable exceptions should be allowed for contracts or service lines that fall outside standard itemization (e.g., bundled payments, DRGs, ACO/shared savings models).

Providers should not be expected to report data that payers treat as proprietary or present inconsistently, as this undermines transparency and introduces further confusion. Clear, operational definitions will ensure fair compliance assessments and improve data usability for consumers, researchers, and stakeholders.

### 2. What are your concerns about the accuracy and completeness of the hospital price transparency machine-readable file data? Please be as specific as possible.

We are concerned that the burden of ensuring data accuracy is disproportionately placed on providers, despite significant challenges stemming from contractual variability, payer-side adjudication rules, and system limitations beyond provider control.

Specific concerns include:

- **Inconsistent payer data feeds:** Many payers do not supply updated contract rates in a usable or timely format, yet hospitals are held accountable for reporting them accurately.
- **Bundled and value-based payment models:** These arrangements do not align with line-item pricing, yet hospitals are expected to “unpack” them for machine-readable files—resulting in artificial data that may mislead rather than inform.
- **Data misuse:** Consumer-facing platforms and media outlets increasingly use MRFs to compare hospital prices without context, ignoring clinical variation, geographic cost differences, and care setting complexities.
- **Patient confusion:** The current system risks increasing confusion rather than clarity for patients, while diverting hospital resources away from direct patient care.
- **Mid-procedure changes:** Medical necessity may require changes during a procedure, making it difficult to reflect accurate pricing in advance.

- **Timing and deductible status:** A patient’s financial responsibility can vary significantly depending on when services are rendered and whether their deductible has been met—factors not captured in static pricing files.

We urge CMS to consider these operational realities when defining accuracy and completeness, and to ensure that compliance expectations are fair, feasible, and aligned with the goal of meaningful transparency.

3. **Do concerns about accuracy and completeness of the machine-readable file data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.**

The current MRF structure presents several challenges that limit its effectiveness for both providers and patients:

- **Limited usability for providers:** Internally, hospitals cannot reliably use MRFs to generate patient estimates, as the file format is designed for regulatory compliance rather than operational utility.
- **Lack of standardization:** The absence of clear definitions for key terms—such as “shoppable service,” “payer,” or “service bundle”—makes meaningful comparisons across hospitals or payers difficult and inconsistent.
- **Erosion of patient trust:** When patients see prices in MRFs that differ from their Explanation of Benefits (EOB), it can lead to confusion and mistrust, even when discrepancies are due to factors outside the hospital’s control.

To improve the structure and utility of MRFs, CMS should consider:

- Requiring standardized file naming conventions and uniform field definitions.
- Differentiating clearly between line-item services and bundled payments.
- Allowing contextual comments (e.g., “Rate reflects global package”) to clarify pricing.
- Implementing service category tagging (e.g., professional vs. technical, inpatient vs. outpatient) to enhance interpretability.

These improvements would support more accurate comparisons, reduce patient confusion, and make the data more actionable for all stakeholders.

4. **Are there external sources of information that may be leveraged to evaluate the accuracy and completeness of the data in the machine-readable files? If so, please identify those sources and how they can be used.**

We urge CMS to proceed with caution when considering the use of external sources to validate machine-readable files (MRFs). While third-party aggregators and health tech platforms may offer useful tools, they often rely on proprietary algorithms and lack the contractual insight necessary to interpret hospital pricing accurately.

External aggregators (e.g., Turquoise Health, media outlets, startups) frequently apply opaque methodologies that do not account for the complexity of negotiated rates, bundled arrangements, or payer-specific adjudication rules. Their interpretations may misrepresent provider compliance and lead to flawed conclusions.

Payer-submitted files, claims adjudication data, or APCDs could support broader transparency efforts—but only if paired with provider input to ensure contextual accuracy and avoid misinterpretation.

Enforcement based on third-party interpretations is especially concerning. While these entities may add value to the ecosystem, their lack of transparency and methodological variability make them unsuitable for regulatory validation without direct provider collaboration.

We recommend that any validation or enforcement framework include provider engagement and transparency in methodology to ensure fairness, accuracy, and alignment with the intent of CMS's transparency goals.

**5. What specific suggestions do you have for improving the hospital price transparency compliance and enforcement processes to ensure that the hospital pricing data is accurate, complete, and meaningful? For example, are there any changes that CMS should consider making to the CMS validator tool, which is available to hospitals to help ensure they are complying with hospital price transparency requirements, so as to improve accuracy and completeness?**

We urge CMS to adopt a collaborative, improvement-oriented enforcement model that supports practical, iterative compliance rather than punitive measures.

Recommendations include:

- Redesign the CMS Validator Tool to include:
  - Crosswalk validation to known CPT/HCPCS codes
  - Duplicate row detection
  - Payer name verification
  - Required field logic (e.g., flagging null negotiated rates unless contractually excluded)
- **Centralized submission portal:** A CMS-hosted, standardized portal would eliminate the need for web scraping, improve version control, and streamline compliance.
- **Grace periods and feedback loops:** Before issuing penalties, CMS should allow time for correction and provide constructive feedback. Many inaccuracies stem from system limitations or payer-side complexity—not from provider negligence.
- **Reframe enforcement:** Shift from a punitive or public-facing compliance model to one that emphasizes collaboration and continuous improvement. Current enforcement actions can feel adversarial, despite providers' good-faith efforts and significant investments in compliance.

A supportive, transparent, and standardized approach will better serve the goals of price transparency while reducing unnecessary administrative burden.

**6. Do you have any other suggestions for CMS to help improve the overall quality of the hospital price transparency machine-readable file data?**

Yes, CMS should take additional steps to align transparency efforts with existing policies and support hospitals in meaningful, sustainable compliance.

Recommendations:

- **Align with the No Surprises Act and Good Faith Estimate (GFE) logic:** Avoid requiring hospitals to build redundant systems with conflicting definitions. Harmonizing these efforts will reduce administrative burden and improve clarity for patients.
- **Provide support for rural and safety-net hospitals:** These providers often lack the technical and analytical resources of larger systems. CMS should offer technical assistance and capacity-building support—not just compliance oversight—to ensure equitable implementation.

- **Protect against data misuse:** Require third parties that scrape or republish machine-readable file (MRF) data to cite original sources and include disclaimers about limitations. This will help prevent misinterpretation and promote responsible use of transparency data.

Hospitals are committed to transparency that enhances patient understanding and access to care. To achieve this, CMS should acknowledge the operational realities providers face and offer clearer definitions, consistent guidance, and a collaborative enforcement approach.